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EDITORIAL

Obstetrician vs. Paediatrician: Does inter-professional indifference compromise emergency caesarean safety?

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Abstract There are times when inter-departmental politics or indifference may sometimes spill onto service provision and threaten to affect patient care. There can be no doubt that an emergency section cannot be delayed indefinitely. An unstable child who requires NICU or transfer can potentially occupy both Paediatric SHO and Registrar for hours. This article raises some concerns and simple solutions, aiming to decrease the friction between Obstetrician and Paediatrician during this particular type of emergency.

There has always been a certain willingness to refer between medical and surgical specialities. There have always been inter-departmental politics in most hospitals, which sometimes spill onto service provision and threaten to affect patient care. This is not a controversial statement. However, one issue where this does seem to come up again and again, which I and numerous colleagues doing six or more months of Paediatrics as an SHO have directly experienced, in hospitals across the UK, is the chaos which sometimes accompanies out of hours or emergency caesarean sections.

There can be no doubt that an emergency section cannot be delayed indefinitely.[1] When baby or mother is in distress, the baby must be delivered as soon as possible. Obstetricians are reluctant to perform emergency caesareans before the child needs to come out, by contrast with elective caesareans, which are performed for many reasons — not all of them are medical.[2] All hospital protocols[3] require the presence of a Paediatrician to receive a baby[4] that might be very premature, in distress, severely malformed or at risk of complications.[5] At the very least staff with training in neonatal resuscitation need to be present. Regardless of a genuine need for resuscitation, there is a mandatory requirement by most if not all protocols for a junior Paediatrician at any emergency or 'risky' caesarean, irrespective of their level of expertise. During office hours this is not usually a problem, many units will have a dedicated neonatology SHO, a registrar can attend at very short notice, and an on-call consultant is in easy-reach. Out of hours and hand over times are more difficult. Out of hours many hospitals will have only one Gynaecology Registrar and SHO and one Paediatric Registrar and SHO, with consultants on call from home.

Most hospitals have seen the wisdom of keeping the delivery suites and obstetric theatres near A&E, but there can sometimes be a distance (as much as half a mile) between children's ward and delivery suites. Similarly if Paediatricians are engaged with an emergency, one of them needs to be released in order to respond to the obstetric summons. In the winter months, it is not uncommon for the A&E resuscitation room to be full of children with severe respiratory distress, and for very sick children to potentially deteriorate on the wards. Difficulty arises because a 'bleep'

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from obstetric theatres often represents a demand to attend at once, without any prior knowledge about the patient and often with no hand over of patient details. The phone call is often made by a midwife or midwifery student who is less likely to know any details. The midwife who does is with the mother. The thinking is clear that if a Paediatrician is in the protocol, he/she must attend. Juniors may find themselves 'threatened' with a clinical incident form if they do not attend promptly. The author's personal experience of hand over meant that a similar type of call from NICU or the general Paediatric Ward was (at the very least) backed up by some foreknowledge of the patient, as well as an idea of whether senior help was needed.

Whereas most emergency caesareans result in healthy babies who begin to cry as soon as they are dried,[6] an unstable child who requires NICU and or transfer can tie up the Paediatric SHO and Registrar for hours. In a climate of 4-h waits in A&E, and during the winter bed crises, this can by itself result in a midnight traffic jam of trolleys consultants and managers. The newborn infant requiring advanced life support is thankfully infrequent.

Since the European Working Time Directive paediatric and obstetric juniors (i.e. sub-consultants) are moving toward a full shift work pattern,[7] and often have a hand over period of 30—60 min for day and night teams to brief one another and hand over outstanding tasks. This hand over seems rarely to be at the same time for Obstetricians and Paediatricians, the latter are often summoned out of hand over to an obstetric emergency. At best this is irritating. At worst it can result in critical details not being handed over.

Hospital trusts should have appropriate staffing levels.[8] It has been suggested that where there is a high rate of complicated delivery or at times of year when there is a high paediatric workload (winter and spring) there should be perhaps be both a neonatology and a general paediatric team out of hours. This only seems to happen in specialist centres. In District General Hospitals it is unlikely that costly additional paediatric staff would be provided to cover the relatively rare event of an infant requiring advanced life support. At times of great stress on the neonatal service, senior neonatal intensive care unit (NICU) staff may attend 'crash' or emergency sections, but this can been stretching the staff in an NICU which may already be full of unstable babies. Some units now have resident consultant Paediatricians on call, which will hopefully improve matters.[9]

So how could one decrease the friction between Obstetrician and Paediatrician?

1. An understanding that elective caesareans which will require a Paediatrician to be present should not be out of hours. In any case an elective section may prove complicated. Similarly there has to be a prompt response by Paediatricians to an appropriate emergency bleep. It is helpful to know how much time there may be (for epidurals, etc.) before scalpel makes contact with skin.
2. *Inter-professional hand over*: a conversation between obstetric and paediatric registrars in identifying mothers who may have difficulties, early indications of foetal distress, etc. with realistic 'guesstimates' of whom may need an emergency caesarean. This will allow an on-call team to make arrangements. Early warning of an impending obstetric emergency can allow the Paediatric team to divide, or ask A&E staff to 'baby sit' a less stable patient, or call in a Consultant. Out of hours Paediatricians conversely need to let the Obstetric team on call know if they are occupied with, for example, a multiple road traffic accident if this means that they are unable to respond to a call for a section.
3. *Having equipment ready in the delivery theatre*: finding things is always harder in an emergency. Paediatricians check the equipment with the hope that it is all there and working properly. Having some details about the mother and baby is also helpful, as the anaesthetist may need the notes. Midwives and Obstetricians 'hand over' very well, and when this does not happen it is usually because of short staffing or the nature of the emergency.
4. If an out of hours neonatology SHO with neonatal advanced life support training is not feasible, perhaps a senior midwife or NICU nurse could be included in the 'Obstetric crash bleep'.
5. Before a complicated in utero transfer is accepted, obstetric and paediatric consultants should make sure that there are facilities to accommodate the potentially unstable infant. NICU cots are not empty for long.

These all seem fairly obvious. It is so obvious in fact that one might assume that there was a universal understanding between medical and surgical specialities of the demands on each, that no elective 'out of hours' procedure made use of an overstretched emergency cover, and that systems are always in place for when things go wrong. That would be a naïve assumption.

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